

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-025850

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 217

FILED JUL 16 1962

VS 300  
Rev. 4/59

1 0017

2 0017

3 2

4 1

5 1

6

7 0

8 2

9578X

10

11

12 3-2

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Adair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville,</b>		Length of stay in 1b <b>12 yrs</b>	c. CITY OR TOWN <b>Kirksville</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <del>XXXX</del> <b>Laughlin Hosp. &amp; Cl.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>615 W. Filmore</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>MATTIE MAY MASON</b>			4. DATE OF DEATH Month Day Year <b>July 10 1962</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> <del>Never Married</del> <del>Widowed</del> <del>Divorced</del>	8. DATE OF BIRTH <b>6/6/94</b>
9. AGE (last birthday) <b>68</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Milan, Sullivan, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U S</b>		13a. FATHER'S NAME <b>John Harris</b>	
13b. MOTHER'S MAIDEN NAME <b>Rozeffa Daugherty</b>		14. NAME OF HUSBAND OR WIFE <b>James A. Mason, Jr.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>N O N E</b>	17. INFORMANT Address <b>James A. Mason Jr. Kirksville, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>72 hours</b>
DUE TO (b) <b>Generalized purulent peritonitis</b>			<b>96 hours</b>
DUE TO (c) <b>Spontaneous perforation of the sigmoid colon</b>			<b>96 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Subcutaneous emphysema due to generalized bacteremia</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <b>July 6, 1962</b> to <b>July 10, 1962</b> and last saw her alive on <b>July 9, 1962</b> Death occurred at <b>4:14 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceased or title) <i>James A. Mason Jr.</i>		22b. ADDRESS <b>Kirksville, Mo.</b>	22c. DATE SIGNED <b>7-11-62</b>
23a. BURIAL / CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>7-12-62</b>	<b>Highland Park</b>	<b>Kirksville, Adair, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Foster Memorial Home, Kirksville, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>7-11-1962</b>	26. REGISTRAR'S SIGNATURE <i>Doris W. Ratliff</i>

PERMIT ISSUED July 11, 1962

JACK A. AUSTER, D.O.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body, whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Nova E. Foster*  
Nova E. Foster

Licensed Embalmer No. 4742

P. O. Address Kirksville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.